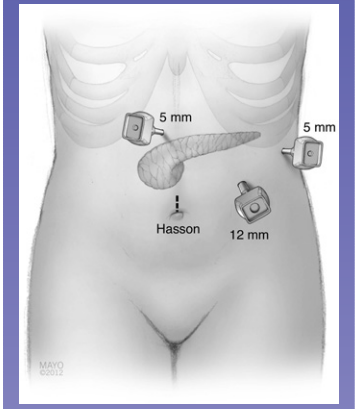
Highlights in this issue



Stauffer *et al.*, p. 149

Multidisciplinary treatment of colorectal cancer metastases: reaching consensus

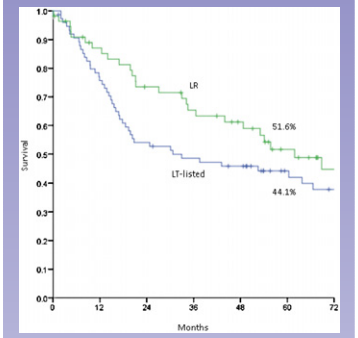
This issue of *HPB* offers the proceedings of the 18 January 2012 *AHPBA/SSO/SSAT Consensus Conference* dedicated to the multidisciplinary diagnosis and treatment of colorectal cancer liver metastases (CRLM). This conference was felt necessary only 6 years after a similar CRLM conference because of the pace, significance and implementation of novel treatment approaches. Over three sessions, international experts assembled to consider and build consensus on issues of selection for hepatic resection, locoregional surgical and interventional therapies, and systemic cytotoxic and biological therapies. This one day conference brought together surgeons, medical oncologists and pathologists to yield a multidisciplinary consensus. Three manuscripts follow which breakdown the topics considered in these three realms, and offer expert consensus statements for each. Further, well known thought-leaders, who served as expert panelists during these sessions, now provide insightful and stimulating commentaries of the conference process and the resulting consensus statements. Historically, these consensus conferences have been very important, productive and well-received. We congratulate all authors and participants for their efforts to advance our knowledge of where the treatment of CRLM is and should be today.

Mark Callery

Management of the incidental liver lesion

With the exponential increase in the use of cross sectional imaging over the last two decades, HPB surgeons are increasingly being asked to advise on the management of benign or incidentally detected mass lesions. In this issue of *HPB, Mezhir et al.* of the Memorial Sloan-Kettering Cancer Center report an 18-year experience in the management of such mass lesions and provide a management algorithm for each individual lesion. A total of 285 patients were identified from their institutional database of which 41% underwent immediate resection. Of the remaining 59% of patients that were followed for a median of 30 months, only 5% (n = 8/168) subsequently underwent resection, none of which had undergone malignant change. Not surprising to most clinicians is the observation of markedly reduced rates of resection due to diagnostic uncertainty in recent years (29% reduced to 13%). One does wonder, however, whether these rates could have been further reduced if there had been more formalized use of MRI as it would appear that only 44% of patients actually had an MRI. From the data provided, it is not possible to tease out the frequency of use of MRI in those with diagnostic uncertainty or by time of presentation. Although these intervention rates may seem high, it is important to assess these data in context because, as the authors rightly point out, there is selection bias due to referral patterns. Furthermore, the review was conducted over a period of significant change and the studied patients made up only 3.4% of the overall proportion of hepatic resections. The strength of this paper is the detailed follow up of patients who were observed. It is clear that once a definitive diagnosis is made of haemangioma or focal nodular hyperplasia then prolonged follow up would seem to be unnecessary as resection will only be indicated if symptoms develop.

Saxon Connor

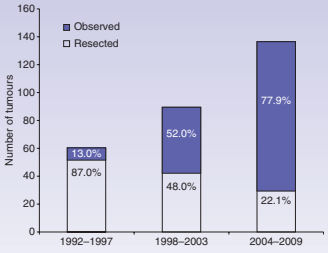


Sogawa *et al.*, p. 134

Liver resection or liver transplantation for solitary hepatitis C virus associated hepatocellular carcinoma?

In the September issue of *HPB* we published a meta-analysis which showed that outcomes for patients with HCC from all causes were better after liver transplantation than after liver resection but that this benefit disappeared when an intention to treat analysis was performed (*Dhir et al.*, HPB 2012; 14 (9), 635–645). In the current issue of *HPB, Sogawa and colleagues* from the Mount Sinai Medical Center present evidence based on patients with hepatitis C virus associated solitary HCC. This group has been the most contentious regarding whether it is better to undertake resection or to transplant the liver. Their study shows that a third of patients with HCV-associated solitary HCC who were listed for transplant died or progressed outside of transplant criteria while waiting for liver transplantation. The intention to treat analysis showed a superior survival of 62 months versus 31 months for patients who underwent liver resection compared with those that underwent liver transplantation; this difference did not achieve statistical significance presumably because the numbers of patients were relatively small. Recurrence rates for HCC were significantly higher in resected than transplanted patients but almost all recurrences were intrahepatic and a third underwent salvage transplantation and 40% underwent either repeat resection or ablation. The decision about how best to manage HCC ultimately depends on the availability of livers for transplantation, the status of the patients' liver function and the outcomes of the individual centre. However, this study clearly shows that, based on intention to treat analyses, resection of solitary HCC on a background of hepatitis C virus is a reasonable strategy to adopt in a landscape with limited organ availability for transplantation.

Stephen J Wigmore



Mezhir *et al.*, p. 156